LaHIPP may pay your employer-sponsored insurance, which is insurance available through your job, if you or a member of your family receives Medicaid.

Employer-sponsored insurance may provide you with:

- Payment for services that Medicaid does not cover
- Healthcare for your entire family—even those not eligible for Medicaid
- Access to more healthcare providers, including many specialists

To Qualify, You or a Member of Your Family:

- Must receive Medicaid benefits
- Must have access to employer-sponsored insurance

Applying for LaHIPP is easy! Just complete the application on the inside of this brochure and:

Fax it toll free to:

1-855-618-5486

Mail it to:

LaHIPP
7389 Florida Blvd. Suite 400
Baton Rouge, LA 70806

E-mail it to:

La.HIPP@la.gov

Do you have questions or need help filling out the LaHIPP application?

We're here to help. Call toll free at 1-855-618-5488, Monday through Friday between 8 a.m. and 4:30 p.m. Or visit us online at our website ldh.la.gov/lahipp.

Note: Photos do not represent actual clients.

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A healthier ***TODAY*** *for a brighter* ***TOMORROW!***

The Louisiana Health Insurance Premium Payment Program

LaHIPP

Application for the Louisiana Health Insurance Premium Payment (LaHIPP) Program

1. Do you or someone in your family currently have or have access to health insurance through a job or through COBRA? ☐ Yes ☐ No If **YES**, select the type of insurance plan you have coverage under:

☐ Individual	☐ Individual + child(ren)	☐ Individual + spouse	☐ Family

2. Complete the following information regarding the policyholder or the person who has a job:

Policyholder's Name:	Date of Birth:
Social Security Number:	E-mail:
Phone Number:	Alternate Phone Number:

3. Complete the following information regarding the health insurance policy and your current employer:

Employer Offering Policy:	Employer Phone Number:
Insurance Company:	Insurance Phone Number:
Policy Number:	Group Number:

4. What is the premium for this policy (if known)? $_____ These premiums are paid/deducted:

☐ Weekly	☐ Bi-weekly	☐ Semi-monthly	☐ Monthly	☐ Quarterly	☐ Other

5. List all persons covered by the policy who are eligible for Medicaid: (use extra paper if needed)

Name	Social Security Number	Date of Birth	Relationship to Policyholder

6. Are any of the persons listed above pregnant, or do any of them have a special medical condition? (use extra paper if needed)

Name	Medical Condition	Name of Birthing Center (if applicable)

7. Payments are made through the Division of Administration's (DOA) LaGov system and can be received electronically via electronic funds transfers. To register with the LaGov system and to enroll in electronic payments, download and complete the **W-9 Form** and **EFT Enrollment Form** from the website below:

ldh.la.gov/lahipp

For faster processing, attach a copy of your **insurance card** if you have one, a **summary of benefits and rates** from your employer, and a recent **pay stub** to show your premium deduction.

After reading the "Your Rights and Responsibilities" section to the right, complete your application by signing below:

Signature: _____ Date: _____

Your Rights and Responsibilities

» I will cooperate in giving LaHIPP information about health insurance from my job and I will enroll in this insurance. I will also enroll dependents who get Medicaid if LaHIPP decides it is cost-effective to help pay for the insurance.

» I will continue to keep group health insurance from my job as long as I get LaHIPP premium payments.

» If I decide that the requirements to enroll or stay enrolled in group health insurance cause me a hardship, I will contact the LaHIPP program and ask for a review of my situation.

» I agree that LaHIPP can contact any person, medical provider, insurance company, employer, or other organization/agency to get information about health insurance, medical treatment and employment for me and/or my dependents.

» I agree to tell LaHIPP within 10 days about:

- changes in what the health insurance covers
- changes in the insurance company
- changes in the cost of the insurance
- if a job ends
- when a pregnancy ends
- if anyone moves out of state
- when Medicare becomes available

» I agree that if I get money from LaHIPP for my insurance that I should not have received, I will have to pay the money back to the Louisiana Department of Health.

» I agree that LaHIPP can use the Division of Administration's (DOA) LaGov electronic system to make payments to me for my health insurance premiums and that LaHIPP can give DOA and my bank any information that they need in order to make those payments. I agree to register with the LaGov system or to allow LaHIPP to act on my behalf to register me, and I consent to all of the applicable terms and conditions for the use of the LaGov Supplier Self Registration Portal. If I wish to receive payments through electronic funds transfers (EFTs) instead of paper checks, I agree to submit an EFT enrollment form that has been filled out by me and my bank.

Fax completed application toll free to 1-855-618-5486
Mail to LaHIPP 7389 Florida Blvd. Suite 400 Baton Rouge, LA 70806
E-mail to La.HIPP@la.gov